

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4934

CERTIFICATE OF DEATH

04933

Reg. Dist. No. 51

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Calvert</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sunderland</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sunderland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Rebecca</u> <u>Emerson</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>5</u> <u>4</u> 19 <u>56</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>March 1</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>P</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Boadley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS. <u>Sala Wilks, Sunderland Md</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <u>450.0</u> <u>Cerebrovascular</u>							<u>4 yrs</u>
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B)							
DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cye</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>19 56</u> <u>58</u> <u>May</u> <u>19 56</u> , that I last saw the deceased <u>alive on</u> <u>May</u> <u>19 56</u> , and that death occurred at <u>9:15 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>H. W. Ward</u> ADDRESS (Street, city, town, state) <u>515/56</u> DATE SIGNED <u>5/3/56</u> M.D. <u>Olving</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		<u>3-7-56</u>		<u>mt Hope</u>		<u>Sunderland md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>5-7-56</u>		<u>H. W. Ward</u>		<u>P. E. Sewell</u>		<u>Prince Frederick</u>	

RECEIVED

BUREAU V. S.

MAY 8 1956

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4935

CERTIFICATE OF DEATH

04934

Reg. Dist. No. 52

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Calvert</i>	MARYLAND	STATE <i>MD</i>	COUNTY <i>AA</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Cherry</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Lothian</i>	TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
<i>Paul Junior Foster</i>		5 26 1956	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
		<i>Single</i>	<i>Sept 25-1938</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<i>Carpenter</i>	<i>Laborer</i>	<i>West Va</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Paul Raymond Foster</i>		<i>Bessie Lephew</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
		<i>234-56-5699</i>	
17. INFORMANT & ADDRESS			
<i>Joseph Carl Lothian Md.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
825X IMMEDIATE CAUSE (A) <i>Injury Chest</i>			
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(B) <i>Fractured skull</i>			
(C) <i>Broken left arm</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
<i>into accident</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or business street, office bldg., etc.)	
		<i>Home 660 Cherry Calvert Md</i>	
21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
<i>Cherry</i>		<i>Calvert Md</i>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work	
<i>5/26/56 8 P M</i>		<i>While at work</i>	
21f. HOW DID INJURY OCCUR?			
<i>Auto</i>			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<i>H. M. Ward</i>		<i>5/26/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. REC'D BY REGISTRAR	
<i>Burial</i>		<i>Grace L. Hutchins</i>	
DATE THEREOF		REGISTRAR'S SIGNATURE	
<i>5/30/56</i>		<i>Grace L. Hutchins</i>	
NAME OF CEMETERY OR CREMATORY		25. FUNERAL DIRECTOR'S SIGNATURE	
<i>Lebron Cemetery</i>		<i>W. H. Hutchins</i>	
LOCATION (City, town, or county)		ADDRESS	
<i>West Va.</i>		<i>Livingston, Md.</i>	

CERTIFICATE OF DEATH

Reg. Dist. No.

II. MEDICAL HISTORY AND CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

PREVIOUS ILLNESS

DIET

SMOKING

ALCOHOL

HYGIENE

EXERCISE

TEMPERATURE

PULSE

BLOOD PRESSURE

URINE

STOOL

SKIN

HEENT

HEART

LUNGS

LIVER

SPLEEN

PANCREAS

PROSTATE

UTERUS

OVARIES

BREASTS

THYROID

ADRENALS

PITUITARY

TESTES

BLADDER

RECTUM

COLON

SMALL INTESTINE

STOMACH

ESOPHAGUS

TRACHEA

BRONCHI

PERICARDIUM

PERITONEUM

PLEURA

DIAPHRAGM

VERTEBRAL COLUMN

SKULL

FACE

NECK

THORAX

ABDOMEN

PELVIS

EXTREMITIES

GENITALS

TEETH

HAIR

SCALP

NOSE

EARS

EYES

MOUTH

PHARYNX

ESOPHAGUS

TRACHEA

BRONCHI

PERICARDIUM

PERITONEUM

PLEURA

DIAPHRAGM

VERTEBRAL COLUMN

SKULL

FACE

NECK

THORAX

ABDOMEN

PELVIS

EXTREMITIES

GENITALS

TEETH

HAIR

SCALP

NOSE

EARS

EYES

MOUTH

PHARYNX

ESOPHAGUS

TRACHEA

BRONCHI

PERICARDIUM

PERITONEUM

PLEURA

DIAPHRAGM

VERTEBRAL COLUMN

SKULL

FACE

NECK

THORAX

ABDOMEN

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EXTRE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If the certificate is not executed within 72 hours after death, it should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4936

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04935

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) County Hosp.		d. STREET ADDRESS 1155 Carey Street	
3. NAME OF DECEASED (Type or print) First John Middle Thomas Last Gross		4. DATE OF DEATH Month May Day 13 Year 1956	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 July 26
9. AGE (In years last birthday) 29 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John C. Gross		14. MOTHER'S MAIDEN NAME Waisy Gross	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-240445	
17. INFORMANT Sarah Zylar Address St Leonard md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Craniocerebral Injury DUE TO 824x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from fender of moving car	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 8:30P p. m. 5/13 19 56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Calvert (County) Md. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Paul F. Guerin		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5/14/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) 5-16-56		22b. DATE THEREOF Brooks	
22c. NAME OF CEMETERY OR CREMATORY Island Creek		22d. LOCATION (City, town, or county) Ind	
23. FUNERAL DIRECTOR'S SIGNATURE P.T. Sewell Prince Fred Md		ADDRESS	
24a. REC'D BY REGISTRAR DATE 5-16-56		24b. REGISTRAR'S SIGNATURE H. W. Ward	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Colony

Maryland

Baltimore

1155 Carey Street

John

Thomas

Gross

May

13

50

Colored

Male

29

BUREAU A. S.
MAY 17 1930

Paul H. Gustin, M.D.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4937

CERTIFICATE OF DEATH

04936

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) p. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEORGES</u> <u>CALVERT</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NORTH BEACH</u>			c. LENGTH OF STAY IN 1b <u>18 YRS</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5TH & ERIE ST.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET TERESA KELLY</u>			4. DATE OF DEATH Month Day Year <u>MAY 15 1956</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-22-1883</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>ALEXANDRIA, VA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>GEORGE WASHINGTON HYDE</u>			
14. MOTHER'S MAIDEN NAME <u>EMMA MARCHER</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>CATHERINE KELLY, SHADYSIDE, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PROFOUND ANEMIA</u> <u>171X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ADENOCARCINOMA OF</u> (c) <u>CERVIX WITH METASTASIS GENERAL</u> 8 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 11. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>June</u> , 19 <u>48</u> , to <u>May 15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 10</u> , 19 <u>56</u> , and that death occurred at <u>10:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dayton Watkins</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>5304 Annapolis Road 5-15-56</u>			
PHYSICIAN'S NAME (Type) <u>DAYTON O WATKINS</u>		<u>Bladensburg Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>18 MAY 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BETHEL CEMETERY</u>	
22d. LOCATION (City, town, or county) (State) <u>ALEXANDRIA, VA.</u>		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Mattingly Funeral Home - WASH. D.C.</u>			
24. REC'D BY REGISTRAR <u>58</u>		24b. REGISTRAR'S SIGNATURE <u>Elin M. Cox</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4938

CERTIFICATE OF DEATH

04938

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. LENGTH OF STAY IN 1b <u>3 1/2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>		d. STREET ADDRESS <u>Plum Point</u>	
3. NAME OF DECEASED (Type or print) First <u>Randolph</u> Middle <u>A.</u> Last <u>Mills</u>		4. DATE OF DEATH Month <u>May</u> Day <u>22</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 14, 1901</u>
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ernest T. Mills</u>		14. MOTHER'S MAIDEN NAME <u>Anne Collins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Elizabeth Mills - Plum Point Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/18</u> , 19 <u>56</u> , to <u>5/22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5/22</u> , 19 <u>56</u> , and that death occurred at <u>7:15 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Huntingtown, Md</u> DATE SIGNED <u>George J. Weems</u>			
ACTUAL SIGNATURE <u>George J. Weems</u>		M.D. <u>Huntingtown, Md</u>	
PHYSICIAN'S NAME (Type) <u>George J. Weems</u>		<u>Huntingtown, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 24-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Weswood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel Bros 1661-9d Hope Rd SE</u>		ADDRESS <u>Wash DC</u>	
24a. REC'D BY REGISTRAR <u>DATE May 22-56</u>		24b. REGISTRAR'S SIGNATURE <u>Edna F. Galtier</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 78

BUREAU V. S.

MAY 23 1956

RECEIVED

INSTRUCTIONS
1
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4939

CERTIFICATE OF DEATH

04938

Reg. Dist. No. 52

1. PLACE OF DEATH COUNTY <u>Cecil</u> MARYLAND CITY OR TOWN <u>Livingston</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>CEC</u> CITY OR TOWN <u>Lothian</u> STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Zinn</u> (First) <u>Mc Coy</u> (Middle) <u>Ridgely</u> (Last) 4. DATE OF DEATH <u>5</u> (Month) <u>26</u> (Day) <u>58</u> (Year)		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u> 8. DATE OF BIRTH <u>Aug 9, 1937</u> 9. AGE last birthday <u>18</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <u>Sawmill</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Forester</u> 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Algeron Ridgely</u> 14. MOTHER'S MAIDEN NAME <u>Maribrie Ridgely</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If Yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT & ADDRESS <u>Algeron Ridgely, Lothian</u>		18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 825X IMMEDIATE CAUSE (A) <u>Fractured jaw and skull</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>rt leg</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Auto accident</u>	
19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. PLACE (Home, farm, factory, or INJURY site, office, etc.) <u>Highway 260</u> 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Livingston</u> <u>Cecil</u> <u>MD</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>5/26/58</u> <u>8P</u> <u>M.</u> 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 21f. HOW DID INJURY OCCUR? <u>Auto accident</u>		22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above. SIGNATURE <u>H W W and D Mc</u> ADDRESS (Street, city, town, state) DATE SIGNED <u>5/26/58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> DATE THEREOF <u>5/29/58</u> NAME OF CEMETERY OR CREMATORY <u>Mt Calvary</u> LOCATION (City, town, or county) (State) <u>Lothian</u> <u>MD</u>		24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE <u>Grace L. Hutchins</u> 25. FUNERAL DIRECTOR'S SIGNATURE <u>M. A. Hutchins</u> ADDRESS <u>Livingston</u>	

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4940

CERTIFICATE OF DEATH

04939

Reg. Dist. No. 52

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Calvert</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Calvert</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Prince Frederick</u>	LENGTH OF STAY (In this place) <u>4 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Owings</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert Co. Hospital</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Henry Francis Stevens</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>5 25 1956</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. SINGLE/MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Apr. 18 - 1881</u>
9. AGE last birthday <u>74</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Francis Stevens</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Sunderland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <u>wife - Margaret Owings Rd.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) <u>Cerebral accident</u>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/24</u> , 19 <u>56</u> , to <u>5/25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5/24</u> , 19 <u>56</u> , and that death occurred at <u>1:05 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>H. H. H. H.</u>		ADDRESS (Street, city, town, state) <u>Mt. Harmony Md.</u>	
DATE SIGNED <u>5/25/56</u>			
23. BURIAL/CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/27/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Mt. Harmony</u>		LOCATION (City, town, or county) <u>Mt. Harmony Md.</u>	
24. REC'D BY REGISTRAR <u>Grace L. Hutchins</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. H. H. H.</u>	
DATE <u>5/26/56</u>		ADDRESS <u>Owings Rd.</u>	

CERTIFICATE OF DEATH

MD. DEPT. OF HEALTH

1. NAME OF DECEASED

John 2

2. SEX

Male

3. AGE

25

4. DATE OF DEATH

June 2, 1936

5. TIME OF DEATH

10:00 AM

6. PLACE OF DEATH

Home

7. CAUSE OF DEATH

Heart failure

8. DISEASE OR INJURY

Myocardial infarction

9. SIGNATURE OF PHYSICIAN

John 2

10. SIGNATURE OF WITNESSES

John 2

11. SIGNATURE OF CORONER

John 2

12. SIGNATURE OF REGISTRAR

John 2

13. SIGNATURE OF CLERK

John 2

14. SIGNATURE OF CHIEF CLERK

John 2

15. SIGNATURE OF ASSISTANT CLERK

John 2

16. SIGNATURE OF DEPUTY CLERK

John 2

17. SIGNATURE OF CHIEF OF BUREAU

John 2

18. SIGNATURE OF ASSISTANT CHIEF

John 2

19. SIGNATURE OF CLERK

John 2

20. SIGNATURE OF CHIEF CLERK

John 2

21. SIGNATURE OF ASSISTANT CLERK

John 2

22. SIGNATURE OF DEPUTY CLERK

John 2

BUREAU V. S.

JUN 4 1936

RECEIVED

4941

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Calvert</i>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. LENGTH OF STAY IN 1b <i>2 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St. Leonards</i>													
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert County Hospital</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <i>Mary</i>			Middle <i>Larner</i>			Last <i>Stratton</i>			4. DATE OF DEATH Month <i>May</i>		Day <i>22</i>		Year <i>1956</i>				
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Negro</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Dec. 21</i>		9. AGE (In years last birthday) <i>49</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Horsework</i>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <i>Maryland</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S. 17</i>					
13. FATHER'S NAME <i>John Larner</i>						14. MOTHER'S MAIDEN NAME <i>Marion Mills</i>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown)		16. SOCIAL SECURITY NO. <i>017-07-7514</i>		17. INFORMANT Address <i>Joseph Stratton - St. Leonards</i>													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension and</i> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>5/20</i> , 19 <i>56</i> , to <i>5/22</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>5/22</i> , 19 <i>56</i> , and that death occurred at <i>7:15</i> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>St. Leonards, Md.</i> DATE SIGNED <i>Ed Williams</i>																	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>5-27-56</i>				22b. DATE THEREOF <i>5-27-56</i>				22c. NAME OF CEMETERY OR CREMATORY <i>White Hall</i>				22d. LOCATION (City, town, or county) <i>Rusby</i>				(State) <i>md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. E. Sewell</i>						ADDRESS <i>Prince Fred</i>						24a. REC'D BY REGISTRAR DATE <i>5-24-56</i>		24b. REGISTRAR'S SIGNATURE <i>H. W. Ward</i>			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be returned by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

15.222

01-07-17

BUREAU V.I.

MAY 25 1956

RECEIVED

2-25-26

1956